

external wounds simultaneously with rupture of the bladder; he observed that at the time of death the wounds presented exactly the same aspect as at the time of admission to the hospital—"they presented no trace of a process of inflammation and repair."

*The mode of death* is directly related, in the opinion of the author, to the absorption of urine by the peritoneum, and its continuous accumulation in the blood, to which condition Coats applies the term "urinary poisoning."

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MODIFICATIONS OF BIGELOW'S OPERATION FOR STONE IN THE BLADDER,  
DESIGNED TO MEET CASES IN WHICH THE PROSTATE IS ENLARGED.

CHISMORE, after speaking of the difficulties attending litholapaxy in the presence of senile hypertrophy of the prostate gland (*Journal of Cutaneous and Genito-urinary Diseases*, 1894, vol. xii.), propounds the following questions: Is it worth while to attempt to remove stone by crushing? Can it be done with sufficient safety, celerity, and certainty to warrant a trial? If so, how shall we proceed in order to minimize the danger and suffering to our patients?

The author's experience has led him to answer the first two queries in the affirmative, and offers the following modifications of the classical operation as a solution of the last:

1. Substituting local for general anæsthesia in cases in which an anæsthetic is required.

2. Short sittings. Continue crushing only as long as fragments can easily be found. Wash out the pieces, and stop the moment symptoms of exhaustion, spasm of the bladder, or unusual distress occur.

3. Remove remaining pieces, after symptoms due to previous operation have subsided, as soon as they can be felt by the searcher—usually within a week—and repeat the process until the bladder is cleared.

If stricture is present gradual dilatation is employed until the calibre is sufficient to admit the necessary instruments, when, at the first favorable opportunity, Chismore draws off the urine with a catheter, injects one or two fluidounces of solution of cocaine hydrochlorate, and proceeds at once to crush the stone. This he does in his office. No prolonged attempt is made to entirely free the bladder, but those fragments only which can be quickly grasped are crushed and removed in the usual manner. If any portion remains, the old symptoms soon recur, and the operation is repeated in the same way, except that frequently no anæsthetic will be required.

Chismore has devised a lithotrite and evacuator combined, which he prefers in all cases in which the stone is not too hard.

A summary of fifty-two cases coming under the above heading is given.

The personal experience of the author leads him to the following conclusions: In all cases of stone in the bladder where senile enlargement of the prostate gland exists, the operation described affords a reasonable probability of success, provided the urethra is or can be made large enough to admit the instruments; that, in such cases, it is possible by this method, with less suffering and danger to the patient, to remove any stone that can be gotten through a perineal incision; that the results are quite as good, both as to relief or recurrence, as those attained by cutting—either "high" or "low"

—and that, as a rule, the time required to clear the bladder is not greater than that which is necessary to recover from a suprapubic lithotomy.

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PERSISTENT ŒDEMA AND ELEPHANTIASIS FOLLOWING EXTIRPATION OF LYMPHATIC GLANDS.

RIEDEL calls attention (*Archives für klinische Chirurgie*, 1894, Band xlvii., Heft. 3 u 4) to the infrequency of reports of persistent œdema or elephantiasis following removal of lymphatic glands. He believes that the cases occur with greater frequency than would be indicated by literature, as he has himself met with three instances. The first patient was a boy, twelve years of age, who suffered from œdema of the entire arm and hand three years after extirpation of the axillary glands. The second case was that of a man with suppurating sinuses, the result of chancroidal buboes, for the relief of which Riedel excised the inguinal glands on both sides. Two years later the patient presented a mild degree of elephantiasis of both thighs and of the lower part of the trunk. In the third instance the inguinal glands of the left side were removed for the same condition as existed in the previous case, and six months later elephantiasis of the skin of the corresponding thigh was apparent. In the last two cases the changes in the skin were associated with attacks resembling erysipelas. In view of these results the author questions the advisability of completely removing the glands in these cases.

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AN ADDITION TO PRESENT METHODS OF CLOSING LARGE CONGENITAL FISSURES OF THE HARD PALATE.

MILTON (*Lancet*, July 14, 1894) reports a case of severe double hare-lip and cleft palate in which he supports the theory of insufficient approximation as the chief factor in the production of the deformity by the following points: (1) the separation between the two halves of the bifid uvula largely exceeded the width of any possible undivided organ; (2) the upper teeth overlapped the under teeth laterally to the extent of three lines on either side; (3) the upper canines coincided when the jaws were closed with the first lower premolars; (4) the expansion of the alæ nasi was one and three quarter times as great as in a normal child of the same stature; and (5) the alveolar process of the inter-maxillary bone projected four lines beyond that of the lower jaw and lay two lines higher than those of the superior maxilla. Convinced that the deformity was due to insufficient approximation, the author grasped the two superior maxillæ with a strong pair of forceps shaped somewhat like lion forceps, and with very considerable pressure, exerted with great care, at once brought together the two maxillæ along the greater portion of the fissure, the only obstacle being the interposed septum nasi. The snout was then forced down to take up its position between the two maxillæ. The sides were held in their approximated position by a wire passed in the groove between the teeth and the gums and across from behind the last premolar on one side to the last on the other, and then tightened by twisting in front. The patient had no reaction after this operation, and wore the wire comfortably for thirty-eight days. The bones retained their new position after its removal, and a plastic operation of the soft parts easily completed the restora-